U.S. Department of Labor

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Issue date: 31Jul2002

Jose Otero
Claimant

2001-LHC-03366

v.

Crowley AmericanTransport
Employer

and

Abercombie, Simmons & Gillette
Carrier

DECISION AND ORDER
APPROVING STIPULATION

This proceeding involves a claim for benefits under the Longshore and Harbor Workers' Compensation Act, as amended, 33 U.S.C. §§901, et seq., (the "Act"), and the regulations promulgated thereunder. The Claimant is represented by David C. Barnett, Esquire, of Dania Beach, Florida and the Employer/Carrier is represented by Lawrence B. Craig, Esquire, of Miami, Florida. On July 22, 2002 Mr. Craig submitted the following:

i. Application for Approval of Agreed Settlement;
ii. Proposed Order; and
iii. Petition for Attorney's Fees.

Additionally, an Itemization of Hours and Costs prepared by Claimant's Counsel was submitted on July 5, 2002.

The parties have stipulated to the following:

1. Date and Description of Incident: The Employee/Claimant, Jose M. Otero, was allegedly injured on June 3, 1999 while standing on a 4-foot ladder; when the ladder slipped, the Claimant fell to the ground, striking his back.

2. Nature of Injury (including degree of impairment and/or disability): As a result of his accident, the Claimant is alleging back injuries, including spinal disc herniations; a knee injury with a request for knee injury; shoulder injuries; and psychiatric injuries.

3. Description of Medical Care (See Composite EXHIBIT "A" for all pertinent medical reports): Following the incident, the Claimant was first seen at the emergency department of the Broward General Medical Center where he was diagnosed with a sprain and contusion to the mid and lower back. The Claimant followed up with Dr. R. Cardella, who provided a June 22, 1999 diagnosis of contusion to the lower thoracic spine and lumbosacral strain also noting complaints of dizziness.

The Claimant also had an initial consultation with Dr. Gary Kelman on July 8, 1999. Dr. Kelman's impression, at that time, was that Mr. Otero had a lumbar contusion; a questionable right sciatica; lumbar discogenic syndrome; and an L5-S1 Grade I spondylolisthesis which was pre-existing. As a result, the Claimant was allowed to work

with restrictions of no lifting, no carrying, no pushing or pulling, no bending at the waist and the opportunity to change positions at will.

The Claimant underwent an MRI scan of the lumbar spine on July 15, 1999, which demonstrated right-sided foraminal stenosis at L5-S1, secondary to spondylolisthesis; L2-3 moderate left and far left disc herniations were noted with some impression of the thecal sac, as well as a small to moderate left-sided disc herniation at T11-12 and T10-11 disc abnormalities. On August 19, 1999, Dr. Kelman re-examined Claimant for his lower back and lower extremity complaints. His impression was that Claimant had a lumbar contusion with some lower extremity symptoms of uncertain etiology. Dr. Kelman also commented on a normal electromyography study of both lower extremities performed by Dr. Bruce Zaret, who found no evidence of radiculopathy or polyneuropathy. Dr. Kelman referred Mr. Otero to Dr. Christopher Brown, a spine specialist in Dr. Kelman's medical group.

Dr. Brown examined the Claimant on August 26, 1999 wherein he found that Mr. Otero had L5-S1 spondylolisthesis, chronic in nature with S1 radiculopathy, which he felt was probably from a recent L5-S1 disc herniation secondary to the work-related injury. Dr. Brown also noted that the EMG nerve conduction tests were negative for radiculopathy, but indicated his belief that Mr. Otero was having radicular symptoms. Accordingly, Mr. Otero was referred to a pain center to possibly have epidural injections and for physical therapy.

Dr. Kelman noted on September 9, 1999 that the epidural injection with Dr. Ira Fox

was performed and provided limited relief. On September 3, 1999, Mr. Otero presented to Dr. Fox for the injection and Dr. Fox performed an L5-S1 trans-laminar epidural steroid injection. On September 24, 1999, Claimant advised Dr. Fox that he had no relief whatsoever from the injection, and he continued with the same pain complaints. Dr. Fox noted that there may have been some secondary adhesions from the inflammation in that area and performed another injection. On October 1, 1999, however, Claimant stated again that he had no relief from the procedure. Dr. Fox noted at that time that Mr. Otero's gait continued as antalgic and that he was still using a cane.

Also at that time, Claimant presented himself to Dr. Kelman for re-evaluation of his

right ankle, and denied any specific injury to it. Dr. Kelman found that there was no obvious

pathology with respect to the right ankle, and strongly recommended a normal gait pattern.

On October 13, 1999, Claimant appeared for a diagnostic intraspinal epidural injection

with interpretation; and a right L4-5 and a L5-S1 myeloscopy (two separate levels) with epidural steroid injection under fluoroscopic visualization procedure.

On October 25, 1999, Claimant appeared at Dr. Fox's office, stating that he had had

no relief. Claimant had seen Dr. Lang (a neurosurgeon) for a second opinion, and was told that he was not a surgical candidate. Claimant's case manager, Ms. Maureen Orr, R.N., mentioned that Dr. Lang felt the herniations were small, and she further stated that he recommended a pain management program. On physical exam on that date, the previous injection sites were clean and non-indurated with no evidence of erythema or

tenderness to touch. Claimant had a significant amount of muscle spasm in the left paravertebal musculature; he was tender on palpation of the bilateral lumbosacral facet joint regions; and his neurological examination was otherwise unchanged. Dr. Fox did not recommend any further interventional treatment at that time and gave Claimant prescriptions for Celebrex and Flexeril for his muscle spasm. Dr. Fox consulted Dr. Deutcher for placement at the Sunrise Rehabilitation Hospital Pain Management Program, for consideration of undertaking peripheral nerve block injections or possible facet blocks, if necessary. Dr. Fox wanted to see how Claimant did with the rehabilitation first; he was to see Mr. Otero again in 4 – 6 weeks.

On November 22, 1999, Claimant continued to deny any relief in his condition. He had multiple pain complaints across the lower back extending to the left buttock as well as the right lower extremity. Claimant was also complaining of associated weakness in the right lower extremity and left facial headaches. Mr. Otero stated that he had been seen by his internist and his sugar was in the 400's and he was on a diabetic diet at that time. On physical examination, the previous injection sites remained clean, non-indurated, with no evidence of erythema or tenderness to touch. Claimant was tender on palpation of the bilateral lumbar facet joint regions; his gait continued antalgic; he continued use of a cane; and he had great difficulty getting up from a sitting position. Claimant's neurological examination was negative for any focal, motor or sensory changes since he was last seen. Dr. Fox opined that Claimant's pain may be discogenic as well as facetogenic; he was not recommending any additional treatment at that time. Dr. Fox thought Claimant needed to participate in an interdisciplinary pain management education as to best live with his condition. Claimant had already been found not to be a surgical candidate by Drs. Brown and Lang. Mr. Otero was requesting additional pain medication; however, Dr. Fox instructed him to discontinue the Celebrex and that he try Vioxx; Dr. Fox also gave him a prescription for low dose Elavil to help him to sleep and, hopefully, to provide some additional pain relief.

On December 6, 1999, Claimant stated to Dr. Fox that he had no relief from the Vioxx; he was getting some improved sleep on Elavil 25 mg., but he had not had any benefit with respect to his pain complaints. Claimant continued to complain of pain in the lower back, the left side somewhat worse than the right, with the pain extending into the right lower extremity. On that date, Claimant's gait, on physical examination, continued antalgic as he was using a cane. He was oriented and responding appropriately; there were no gross motor or sensory changes since last seen; he had some pain on palpation of the bilateral lumbosacral facet joint regions and his pain exacerbated with extension and rotational movement. Dr. Fox opined that the patient's pain might be multifactoral; that he was awaiting placement in the interdisciplinary pain management program, and had an appointment with Dr. Deutscher the following week. In the interim, Dr. Fox increased his Elavil to 50 mg. and commented that they may want to consider treating a facetogenic component to his pain. Dr. Fox asked the case manager, Ms. Orr, to refer the patient back for possible facet injections pending his response to the first couple of weeks of the pain program.

On December 29, 1999, Claimant stated that he was getting some relief while participating in the interdisciplinary pain management program. He continued with complaints of pain in the lower back extending into the right lower extremity. It was previously discussed that a possible trial of facet joint medical branch nerve blocks for diagnostic and potential therapeutic benefit and the right lumbosacral facet joint medial

branch nerve block injections at L2, L3, L4, L5 and S1; and a contrast injection under fluoroscopic visualization for needle placement and spread of medication verification procedures were undertaken. After the procedures, the Claimant was evaluated with respect to his pain response, and he was given an opportunity to sit, stand, ambulate, flex and extend his lower back. Claimant stated that his pain improved from a 5 to a 3 using a numeric rating scale.

On January 10, 2000, Claimant stated that he had had no relief from the injections; he was overall somewhat improved with the rehabilitation program and complained of less "spasms" in his lower back. He persisted with severe pain complaints in the right lower extremity. On physical exam, the previous injection sites were clean and non-indurated with no evidence of erythema or tenderness to the touch. Claimant's gait continued antalgic. Dr. Fox was not recommending any further interventional treatment at that time. He felt that Mr. Otero may be a candidate for provocative discography if Dr. Brown had not had any changes in mind with respect to possible surgical intervention. In the interim, Dr. Fox gave Claimant a prescription for Neurontin (an anti-neuropathic); Claimant was to follow-up with Dr. Deutscher and the medication could be increased if it was helping him. He would get up to 900 mg. a day over the next nine (9) days. Dr. Fox also explained to Mr. Otero the necessity that he see his private medical doctor regarding his persistent hypertension and it was noted that Mr. Otero understood the instruction.

On May 12, 2000, Claimant stated that he had been through the pain management program under the direction of Dr. Deutscher which Mr. Otero felt had helped somewhat. Claimant was persisting with severe complaints of pain in the lower back and right lower extremity; and complaining of pain extending to the right thoracic paraspinal regions. On physical examination, Claimant had less tenderness on palpation of the bilateral lumbosacral facet joint regions; his pain exacerbated with both flexion and extension movement; the neurologic examination was negative for any gross changes since last seen. Claimant had multilevel disc disease. His pain was most severe in the lower back and right lower extremity, and this was likely related to right L5-S1 radiculopathy with possible discogenic pain at that level, as well as at L4-5 where disc protrusion on MRI was also noted. The Claimant had a left sided herniation at L2-3, but Dr. Fox felt that this was less likely responsible for his pain. He also had small to moderate sized left handed herniation at T11-12 and abnormality at T10-11. Dr. Fox would do the discogram with a left sided approach at the L5-S1, L4-5 and L3-4 levels and they would do L2-3 prn. In the interim, Claimant was to continue on a Duragesic patch 25 mcg. as prescribed by Deutscher.

On May 31, 2000, Claimant underwent the provocative discography at L2-3, L3-4, L5-S1, under fluoroscopic guidance; the lumbosacral discogram; and the intradiskal manometry. At the completion of these procedures, Claimant was taken to the recovery room in stable condition; he had an unchanged neurological examination for baseline; the injection sites were sterilely dressed; and the Claimant was taken to the CT scanner. On that date, Dr. Fox believed that this was a valid and appropriate provocative discogram. Mr. Otero had some pain at L4-5 and L5-S1 in the lower back which was nonconcordant; the pain did not extend into the extremities. His lower back pain was more severe at L2-3, but described as not as severe as what he typically would get. Level 3-4 was a completely normal disc as expected. At no point was any of his lower extremity pain reproduced. There was normal morphology identified particularly at L4-5 and L5-S1, but also at L2-3.

On June 7, 2000, Claimant's pain was at baseline. He denied any neurologic

changes in his condition. On physical exam, the previous injection sites were clean, nonindurated, with no evidence of erythema or tenderness to touch; his range of motion was unchanged; neurologic examination was negative for any gross motor or sensory changes since last seen. Claimant's L3-4 was a normal disc and completely nonpainful; the L4-5 and L5-S1 produced noncordant lower back pain that was noticeable, but not severe; L2-3 was the most painful, but did not produce pain that he considered as severe as what he would typically get; no lower extremity pain was reproduced; and Claimant's post-discography CT scan showed bulging at L4-5 and L5-S1. Dr. Fox asked Claimant to follow up with Dr. Brown, to continue on his medication as prescribed by Dr. Deutscher and to continue his home rehabilitation regimen.

From medical records dated March 7, 2000, Dr. Kelman opined that Claimant could return to work full-duty as of that day, and that Dr. Brown had also released the Claimant to full-duty status. However, after receiving the MRI results evidencing a torn right medial meniscus with mild degenerative changes in the medial patellofemoral compartments, Dr. Kelman opined that the Claimant might be a candidate for arthroscopy. The right knee MRI was undertaken on April 24, 2000. Dr. Kelman was also at a loss to explain the Claimant's right ankle pain in light of his normal MRI of the ankle, which was undertaken on May 24, 2000. He recommended referral to a podiatrist in this regard, and Arthur Segall, Jr., D.P.M. evaluated the claimant on July 18, 2000. On that day, Claimant complained that because he was walking abnormally, he developed right hip, knee and ankle pain.

Dr. Segall reviewed the MRI findings and concurred with the radiologist that they were unremarkable, except for minimal Achilles tendonitis. The x-rays of the ankle on that day were also normal. The Claimant was diagnosed with right ankle sprain/strain syndrome, altered by gait mechanics and back injury. It was recommended that a semi-solid AFO provide mechanical support to the right leg and ankle.

Dr. Brown's report of June 26, 2000 stated that Claimant's discogram was non-conclusive, and he was still complaining of pain radiating down his right lower extremity, as well as down the left upper extremity. Claimant's neurological examination was normal, and he was diagnosed with disc herniations at L5-S1, L2-3 and T11-12. Because Dr. Brown could not pinpoint where the Claimant's pain was coming from, he placed him at MMI and stated that he could return to work with restrictions. Dr. Brown also opined that the Claimant had a 9% permanent impairment rating for the two-level lumbar disc herniations, and one-level thoracic disc herniation.

During a Functional Capacity Evaluation on February 9, 2000. Claimant reported pain consistently during dynamic resistive activities; and therefore, the therapist believed that maximum effort was given. Claimant was placed within the medium work classification category, with the ability to sit and walk frequently, and push/pull a cart loaded with 50 pounds on a frequent basis.

Dr. Lang's neurosurgical consultation of October 25, 1999 noted that the Claimant had a previous work-related injury in 1991, and that his EMG/nerve conductions studies were normal. Claimant's neurological examination was normal, except for decreased sensation

on the right leg and a non-anatomic distribution, along with limitation of range or motion of the lumbar spine. Dr. Lang believed that the Claimant was not a surgical candidate at the time, although he was having rather severe myofacial pain syndrome. He, therefore, recommended that the Claimant was a candidate for a very aggressive pain team type of approach used at the University of Miami, or a similar program.

Records from Dr. Matthew Deutscher revealed that, on December 14, 1999, Claimant presented to Dr. Deutscher complaining of low back pain that started in his central low back extending from the central low back to the posterior thigh on the left side. Claimant's pain was reported as being a grade "5 to 6 out of 10." Claimant did have a history of a prior work injury in 1991, but his pain complaints at the time of that initial accident were not similar to those he was experiencing on December 14, 1999.

On December 14, 1999, Claimant's pain was characterized as "burning and numbness", and the pain was exacerbated with gait. Claimant's lower extremities felt weak and they did buckle. Again, walking, weight bearing and prolonged sitting exacerbated his pain, and it was diminished at times when he lay supine with a pillow under his low back. The pain would wake Claimant up at night and he could not go back to sleep. Claimant reported that physical therapy did not help; that he had three epidural injections which did not help; that he had never had a pain management program; that Celebrex, Ultram and that muscle relaxers did not help him.

In his December 14, 1999 admission plan, Dr. Deutscher opined that Claimant had multifactoral pain or symptomatology, and that Mr. Otero was complaining of pain consistent with a bilateral radiculopathy, and diagnostic imaging revealed that he did have L5-S1 radiculopathy, and disc protusion with neural foraminal narrowing; spondylolisthesis, grade 1; multilevel protruding discs; possible discogenic painl and herniated L2-3; as well as possible T11 and 12. Dr. Deutscher also stated that Dr. Fox felt it might be lumbosacral facet and sacroiliac arthropathies, to which Dr. Deutscher agreed. The plan was to start Claimant on an outpatient pain management program five days a week to be transitioned to a work hardening program, followed by a functional capacity evaluation, and return to work once the pain management program was completed.

On February 29, 2000, Claimant stated that his pain never goes away. There was pain in his right knee and that he wanted to see Dr. Brown for an MRI. Claimant had completed the FCE and Dr. Deutscher released him to medium duty work, starting part time and progressing to full-time. The records contain an April 29, 2002 report where Dr. Deutscher indicated that Claimant was suffering from right knee pain and that he had an MRI on April 24, 2000 revealing a medial meniscus tear on the right side as well as the patellofemoral degenerative changes and a joint knee fusion. Dr. Deutscher noted that he believed that Claimant needed an orthopedic evaluation for possible definitive surgical treatment of the problem.

Claimant was seen for psychiatric care from Dr. Gregg Friedman. During such treatment, Claimant subjectively complained of becoming "very depressed over the pain and the associated physical limitations." Dr. Friedman reported insomnia, crying spells, poor appetite and a ten pound weight loss over a period of a year. Dr. Friedman also adds low energy levels, decreased libido, poor concentration, social isolation, loss of interest in his usual activities and feelings of hopelessness. The only positive notation was that he

denied suicidal ideations. Based upon the "mental status exam," Dr. Friedman opined that Claimant suffered from severe, major depression that was related to the accident in question. He added that he did not feel that Claimant was capable or working, and provided him with a ten day supply of Selexa and Ativan.

At the request of the Employer and Carrier, the Claimant was examined by Dr. Thomas Goldschmidt, a psychiatrist. On September 11, 2001, Dr. Goldschmidt diagnosed malingering; personality disorder with passive-aggressive and dependent features which were not workers' compensation related; undifferentiated somatoform disorder, not workers' compensation related; and status post lumbar strain which had resolved. Dr. Goldschmidt noted that the subjective complaints were not consistent with the objective findings. Specifically, Dr. Goldschmidt found that Claimant's behavior was being orchestrated by his passive-aggressive and characterlogical underpinnings in addition to his conscious motivation to exaggerate his physical and psychological symptomotology for purposes of secondary gain. Thus, Dr. Goldschmidt found that the claims of depression secondary to his injury were contrived and that his psychiatric quirks should have alerted healthcare providers to his malingering. Dr. Goldschmidt noted that Claimant was treated with multi-antidepressants, anti-anxiety, anti-psychotic therapy and that Mr. Otero actually got worse during such treatments with the highly unusual late development of paranoia and delusional ideation in addition to feigned flashbacks of his "trivial fall." Therefore, Dr. Goldschmidt reported that one would have to question whether the examinee was even taking his psychotropic medication.

Additionally, Dr. Goldschmidt noted that Claimant had documented normal motor examination during his course of treatment and that he displayed an unusual gait whereby he would ambulate on the lateral aspect of his foot. Dr. Goldschmidt found that such a maneuver was impossible to account for since it would take considerably more effort to walk on the outside of the foot than it would to walk in the standard bipedal fashion. Additionally, Claimant had normal EMG/NCS of his lower extremities and disconcordant discogram testing. According to Dr. Goldschmidt, Claimant complained of pain even when normal discs were injected, and he never was able to describe a dermatoma distribution to his pain after L5/S1 disc injection. Moreover, the MRI of the lumbar spine revealed chronic degenerative changes unrelated to the subject injury. Nevertheless, Dr. Goldschmidt noted that Claimant failed to also respond to selective epidural injections and that it was quite unusual that he maintained that his pain was constant. Dr. Goldschmidt also noted that Claimant appeared particularly well-muscled and walked without a cane or would use it as a "fashion accessory" when he was unaware that he was being observed.

4. Compensation Paid: The Claimant received temporary total disability payments from June 4, 1999 to February 26, 2002 in the amount of a compensation rate of $623.13, for a total of $88,929.55. Partial permanent disability benefits in the amount of $356.47 per week has been paid from February 27, 2002 and continuing through May 7, 2002, for a total of $3,564.70.

5. Terms of Settlement: The Claimant and the Employer/Carrier have agreed to resolve all allegedly past due benefits, and the Claimant has further agreed to waive his right to any further Longshore & Harbor Workers' indemnity or compensation benefits payable as a result of this claim in return for the Employer/Carrier agreeing to pay the Claimant

$60,000.00. This sum represents any and all potential or temporary total or temporary partial disability compensation, wage loss benefits, permanent partial or permanent total disability compensation, and rehabilitation benefits under the Longshore & Harbor Workers' Compensation Act, to which the Claimant might presently be entitled, or to which he may, in the future, become entitled, as well as any rehabilitation efforts to which the Claimant might become entitled to receive from the Employer and/or its Carrier, under the provisions of the Longshore & Harbor Workers' Compensation Act. In reaching this agreement, the parties have considered the present value of all future payments of monetary compensation, impairment benefits and death benefits, potentially payable to the Claimant on account of the accident referenced herein. The Claimant agrees that the settlement drafts may be sent to his attorney, and his attorney agrees to accept them for the Claimant.

a. Compensation	$60,000.00
b. Medical (future)	40,000.00
c. Attorney's Fees and Costs	24,000.00
Total	$124,000.00

6. If settlement of medical benefits:
   a. Itemization of medical expenses for the past three (3) years: SEE EXHIBIT "B;"
   b. Estimate of future medical expenses (include inflation and discount factors):

   The Employer/Carrier contends that the Claimant has in the past, and is currently exaggerating his symptoms, and that no future medical care is necessary. However, in the unlikely event that Mr. Otero does require future medical care, the parties agree to set aside $40,000.00 for this expense, and the Employer/Carrier's responsibility for all medical care shall be discharged upon payment of this sum.

7. Reason for settlement (including disputed issue(s)): It has been the Employer/Carrier's

contention throughout the claim that the Claimant can return to work, full-duty, without any restrictions, or alternatively, that Mr. Otero could return in the sedentary to light-duty capacity as provided by Theodore Bilski, C.D.M.S. in his enclosed labor market survey report, dated February 21, 2002.

It must also be emphasized that Mr. Otero's claim originally started with symptoms and

complaints subsequently migrated to his right knee, ankle, alleged shoulder and most recently, allegedly manifested psychiatric complaints and conditions as diagnosed by Dr. Friedman.

As indicated above, however, Dr. Goldschmidt has essentially opined that Mr. Otero fit

the profile for a malingerer based on the lack of any objective findings for his physical

complaints, and that he had elevated F scale scores on his MMPI. Moreover, the Employer and Carrier had obtained significant surveillance videotape which demonstrated amongst other activities, Mr. Otero caulking a window; driving on numerous occasions; bending over on numerous occasions; mowing his lawn; switching his cane between both hands or simply not using the cane at all; all of which could not be done by one claiming the injuries that Mr. Otero was claiming. Additionally, there was surveillance obtained when Claimant was moving freely on the same date that he visited his physicians complaining of severe pain and limitations on the same date. These films directly contradicted Mr. Otero's complaints.

In addition to the subsequent right knee, right ankle, alleged shoulder and psychiatric

complaints, which came along a rather significant time after the initial back complaints, diagnoses and treatment, the Emplyer/Carrier had filed an 8(f) Application for second injury fund relief, and the Claimant had also been diagnosed with various debilitating conditions aside from the subject accident such as Hepatitis C, diabetes and high blood pressure. This, unfortunately for Mr. Otero, would affect his life expectancy, and thereby impact to some extent upon the value of the claim.

The Employer/Carrier had also obtained a labor market survey, dated February 21, 2002, from Theodore Bilski, C.D.M.S., the Employer/Carrier's vocational rehabilitation expert who found jobs for the Claimant in the sedentary to light-duty capacity in the $8.00 to $10.00 per hour range. Thus, the present value permanent partial exposure would be reduced accordingly.

In reaching this agreement, the parties have considered the value of past monetary compensation benefits and the present value of future payments of monetary

compensation,

impairments benefits and death benefits potentially payable to the Claimant on account of the accident referred to herein. In arriving at the stipulated settlement amount, the parties have taken into consideration the Claimant's age of 50 years, his life expectancy of 28.7 years, as established by the U.S. Department of Health and Human Services, and also the statutory percentage discount rate tables. Consideration has also been given to the possible loss of cost of living increases due under the Longshore & Harbor Workers' Compensation Act and to the right of the Social Security Administration to offset disability payments payable under this federal law.

Specifically, the parties agree that in arriving at the amount of the lump sum settlement,

the parties have recalculated the Claimant's weekly compensation rate to $40.20 per week. This amount was arrived at by dividing the net indemnity Workers' Compensation lump sum settlement of $60,000.00 by the Claimant's life expectancy of 1,492.4 weeks. The prior Workers' Compensation rate was $356.47.

In reaching this agreement, the parties have considered the value of past medical benefits and the present value of future medical potentially payable to the Claimant on account of the accident referred to herein. In arriving at the stipulated settlement amount, the parties have taken into consideration the Claimant's age of 50 years, his life expectancy of 28.7 years, as established by the U.S. Department of Health and Human Services, and also the statutory percentage discount rate tables.

Specifically, the parties agree that in arriving at the amount of the medical lump sum

amount, the parties have recalculated the Claimant's weekly medical expenses to $26.80 per week. This amount was arrived at by dividing the net medical lump sum amount of $40,000.00, by the Claimant's life expectancy of 1,492.4 weeks. The parties further recognize that these funds are to be utilized for prescription costs and occasional home attendant care costs as the Claimant has completed all conservative care and is currently receiving paliative care and this is documented and confirmed by the report of Dr. Deutscher, the Claimant's treating physician.

Therefore, the parties decided that, given the countervailing evidence in this case, it would be in the best interests of all involved to amicably resolve this claim. In addition, given the uncertainties of litigation, the parties are desirous of resolving this matter without the continued expense of proceeding through additional litigation activity including possible appeal.

8. Claimant's Date of Birth: 05/26/52

9. Claimant's ability to work (including educational background, present work status, work history (if applicable): The Employer/Carrier contended that Mr. Otero could return to work full-duty based upon surveillance obtained; and alternatively, that he could return to work in the sedentary to light-duty capacity as provided by Theodore Bilski, C.D.M.S., in his enclosed labor market survey, dated February 21, 2002.

10. Adequacy of Settlement: This settlement is adequate in that the parties realize the uncertainties of litigation, and are desirous of resolving this matter without the continued expense and unpredictability of a Formal Hearing.

In support of the fee request, counsel for Claimant advises that he has been practicing law in the State of Florida since 1991. Mr. Barnett's practice is limited to representing injured workers in state compensation claims, longshore and harbor workers' compensation claims and *Jones Act* claims. Additionally, Claimant's counsel provides that, in addition to his trial experience, he frequently lectures throughout the State of Florida on workers' rights and has had articles published on crew member rights. An itemized statement of the extent and character of the necessary legal services performed was submitted. Claimant's counsel has expended a total of 139 hours on this case.

I have reviewed the claim file, the documents presented and the stipulations submitted. I note that the attorneys fee is reasonable and necessary for the services performed. As this is a stipulation before the Office of Administrative Law Judges, approval by the District director is unnecessary. Upon careful review of the documents provided, I accept the stipulation and make the following findings and conclusions:

FINDINGS OF FACT And CONCLUSIONS OF LAW

The following findings of fact and conclusions of law are made:

1. The agreed settlement is adequate and not procured by duress;
2. Settlement in the amounts set forth in the Stipulation is hereby approved and the Parties are directed to carry out the requirements of the settlement;
3. The liability of the Employer and Carrier for all payments of compensation and medical under the Longshore and Harbor Workers' Compensation Act, resulting from the Employee's accident and injuries of June 3, 1999, will be discharged upon payment of the agreed upon sums;
4. All benefit payments will cease upon the approval of this 8(i) Stipulation; and

5. The Employer/Carrier shall pay $24,000.00 as an attorney's fee and costs to David C. Barnett, Esquire, for services rendered on behalf of the Claimant; such fees shall be paid to said attorney and shall be paid in addition to the compensation payable to the Claimant.

Now, therefore, under 33 U.S.C. Section 908(i), the settlement is approved, and the terms of settlement are **ACCEPTED** upon the Findings and Conclusions set forth above.

SO ORDERED

A

Daniel F. Solomon
Administrative Law Judge